Improvements Added After Draft Version sent to Health and Welfare Committees in January

As a direct result of feedback from the Health & Welfare Committee hearings in January, input received at public forums and countless meetings with providers, advocacy groups, health care organizations and other stakeholders, DHH has made several improvements to the Notice of Intent for Coordinated Care Networks (CCN). The improvements and corresponding page of the NOI are listed in the table below. More information about the proposal is available at www.MakingMedicaidBetter.com.

Improvement	NOI Page
Added language to allow the development of an alternative Medicaid managed care program.	2
Added language to provide the opportunity for an equal number of prepaid CCN (CCN-P) and shared savings CCN (CCN-S) in each Super Region	3
Removed variation in choice for recipients in urban and rural parishes. Must now be the same.	
Added language encouraging recipients to contact providers in advance if they are unable to make appointments	24
Added language (assigning members of family units to the same CCN) adding a factor that shall be taken into consideration in the automatic assignments process for enrollment.	12
Removed requirement for the CCN-P and CCN-S to be licensed Medical Needs Review Organization at the request of Department of Insurance, as they explained they do not have authority to license as MNRO.	
Added requirements for participation in DHH's established administrative simplification and quality improvement committees to provide recommendations for possible standardization for the CCN Program.	32 & 60
Added requirements for Member and Provider Manuals requirements.	32-37 & 60-65
Clarified preprocessing requirement for CCN-S and timelines for completion.	38
Added Utilization Management requirements to replace requirements that would have been in the MNRO requirements. Requirements include who (qualifications) is authorized to determine medical necessity, appropriateness of care, level of care, service authorization (approval/denial) and what methodology and source of criteria and guidelines utilized.	40-46 & 73-77
Removed the per-member, per-month (PMPM) amount that must be reimbursed to primary care physicians (PCPs) under the CCN-S. Requirement remains in the RFP and will require an amendment to the contract to change as with all PMPMs paid by the department. RFP requirement is $1.50 PMPM.	
Added the range of the percentage of the Enhanced Primary Care Case Management (ePCCM) fee the CCN-S is at risk for returning.	48
For CCN-Ps, added prudent layperson language and defined emergency medical condition as 42 CFR §438.114 and payment in accordance with 42 CFR §422.113 (must pay the FFS rate)	66-67
Added language that GME, UPL, DSH payments will continue according to methodology consistent with existing rules.	79
Added language that Medical Loss Ratio shall be 85%, using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR §158, with time tables for reporting and if refund is required, when refund must be paid, and we will post the audited MLR report on website.	80
For CCN-P, added clarifying language concerning network provider reimbursement: **a. In-Network Providers**	

Improvement	NOI Page
i. Reimbursement for covered service shall be equal to or greater than published Medicaid FFS rate in effect on the date of services.	82
ii. Upon request by a network provider or potential network provider and with prior approval of the department, exceptions may be granted. (CCNs are prohibited from proposing a reimbursement rate that is less than the Medicaid FFS rate in effect on the date of services to the provider.)	82
b. Out-of-Network Providers	
i. Not required to reimburse more than 90% of FFS to whom they have made at least three documented attempts to include them in their network.	83
ii. If three attempts are not documented, then they have to pay 100%.	
c. Emergency Services, whether In or Out-of-Network providers	83-84
i. They are financially responsible for ambulance services, emergency and urgently needed services maintenance and post stabilization care services in accordance with provisions set forth in 42 CFR §422.113.	
Added clarifying Prompt Pay Requirements for CCN-P a. 90% of clean claims must be paid in 15 business days, and 99% must be paid in 30 calendar days.	85
Added claims management language requiring the CCN-P to process claims in accordance with DHH requirements.	85-86
Added Provider Claims Dispute for CCN-P language requiring a. An internal claims dispute process in compliance with DHH requirements b. Contract with an independent review organization c. Report status of all disputes and their resolution to the department on a monthly basis.	86
Added Claims Payment Report requiring an audited claims accuracy report to the department on a monthly basis.	87
Added language allowing providers to file a grievance on behalf of a member.	98 & 115
Reduce the timeframe from which a CCN-P can make a decision on expedited appeals for services. Language included "72 hours or as expeditiously as the member's health requires."	111
Added language clarifying that nothing contained in any document shall preclude a CCN provider's right to pursue relief through a court of appropriate jurisdiction.	120
Added language to require reporting of all provider grievances and appeals filed, along with resolutions, on a monthly basis.	120
Added sanction language if the CCN-P fails to comply with prompt payment requirements.	125
Added sanction language of fines up to $10,000 per incident if CCN does not maintain network adequacy for mandatory provider types.	125-126
Added sanction language if grievance decisions appealed for medical necessity to a state fair hearing level for a recipient or provider have been reversed or otherwise resolved in favor of the member/provider, if they exceed a percentage specified by the department.	126
Added audit language requiring CCN: a. Maintain supporting financial information to ensure that payments are made in accordance with federal and state requirements. b. Place no restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to ensure quality, appropriateness of timeliness of services and reasonableness of their costs.	129-130